16. MUSCULOSKELETAL MANIFESTATIONS OF INFECTIVE ENDOCARDITIS

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Introduction: Musculoscheletal manifestations in patients with infective endocarditis (IE) constitute 28-50%: artralgias (30%0, mialgias (20%), lumbalgias (16%), artritis (5,4%) and sinovitis (2,8 %). In mitral valve implication the rate of mortality consists from 37%, but in IE that is complicated with congestive heart failure – 65-85%.

Clinical case: Pacient X, 71 years old, Diagnostics: active IE, stafilococcical etiology, with MV afecting (vegetations 2,5 mm), MV failure III degree, TsV failure II degree. HF III NYHA. Osteoartrosis, nodular form, III degree in association with rheumatoid artritis, poliartritis III degree. ACVD. Ictus in medium cerebral artery in the left.

Results: subfebrility, palpitations, artralgias, fatiguee. Objective: hemiparesis in the right, motoric afazy, morning stiffness – 2 hours, simetric artritis in the metacarpo-falangian region, proximal interfalangian region, palore of the skin. Cardiac sounds are rhythmic, BP-170/80 mmHg. FCC-96 b/min. Hemoculture - *Staphylococcus aureus*. Leucocitosis, limphopenia, ESR elevated. Biochemistry: Pozitive Latex test, hipercreatininemy, uremy, elevated range of transaminasis. Urine analisys: leucocitury, hematury. ECG: Synusal tahicardy 100 b/min, left venrticle hypetrophy. Computer tomography (CT): CT sighns for ictus ischemic on the left. Multiple consecuances of the lacunar infarction that was supported bilateral in external capsula.

Treatment: antibacterian, antimicotic, nonsteroidal antiinflamatory drugs, rheological, vascular, antiaritmic, diuretics.

Conclusions: patients with IE with the background of rheumatoid artritis usually presents stafilococcical *trigger*, afecting mitral valve, complicated with congestive heart failure, ictus and cerebral oedema, that fatal defavorisates the prognosis.

Key words: endocarditis, reumatiod, artritis, staphilococical

17. AGGRESSIVE APPROACH IN GLIOBLASTOMA MULTIFORMEA. RARE CASE OF LONG TERM SURVIVAL

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Introduction: Glioblastoma is the most common and aggressive primary brain tumor and, as a result, carries a very poor prognosis. Although average survival period ranges from 6 to 12 months

depending on the patient's age, performance status and response to treatment, some cases of long term survival have been reported in the literature. The factors that influence long-term prognosis are not yet understood.

Clinical case: We report the case of a 63 year old man that gets diagnosed with Glioblastoma Multiforme (GBM), undergoes subtotal resection, but radiotherapy and chemotherapy are performed 4 months after the surgery due to patient non-compliance. In this 4 moths the tumor increased in size becoming an inoperable tumor. After receiving adjuvant therapy consisting of radiotherapy concomitant with Temodal, followed by 12 cures of chemotherapy with Temozolamide, the tumor progression and size was reduced in the course of 27 months from 43mm to 35mm and is well managed today. The patient currently has an Eastern Cooperative Oncology Group (ECOG) score of 1 and has a rare 3-year long term survival as a result of the adjuvant therapy.

Conclusion: For a better understanding of the reasons behind long term GBM survivors, it is of vital importance to study and understand each and every case of the sort as it may provide crucial information for future treatment development.

Key words: Glioblastoma Multiforme, Long term survival, Temozolamide

18. EARLY PHYSICAL THERAPY IN INTENSIVE CARE UNIT IMPROVES OUTCOME IN AN ACUTE RESPIRATORY FAILURE DUE TO CHRONIC OBSTRUCTIVE PULMONARY DISEASE COMPLICATED WITH PNEUMONIA

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Introduction: Physical rehabilitation plays an important role in the management of critically ill patients. An early physical therapy intervention will improve mortality such improving survival, the quality of life – prolonged bed rest will lead to muscle atrophy and functional impairment. In order to monitor the benefits induced by physical rehabilitation we monitor the arterial blood gases and at the admission in the ICU the APACHE II (Acute Physiology and Chronic Health Evaluation II) and SAPS (Simplified Acute Physiology Score) scores to determine the mortality risks and the SOFA (Sepsis-related Organ Failure Assessment score) score was used for the management of the outcome, being a prediction score.

Clinical case: A 73 years old female patient known with atrial fibrillation, cardiac failure, hypertensive and chronic obstructive pulmonary disease (COPD) was admitted in the Intensive care Unit (ICU) with an acute respiratory failure due to a pneumonia. At the admission the patient was on ventilatory support with a Glasgow Coma Scale of 13. The APACHE score was 17 with a predictive mortality of 22% and the SAPS score was 45 predicting a mortality of 34.8%. An individualised physical training was established. The ends points of physical rehabilitation were: the maintaining of the ph to normal values, the lowering of the pCO_2 from hypercapnic to normal values, the amelioration of the